

State of California

MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Forum on Triage
February 13, 2017

Sacramento Convention Center
1400 J Street, Second Floor, Room 202
Sacramento, California 95814

Members Participating:

John Boyd, Psy.D., Vice Chair
Lynne Ayers Ashbeck
Sheriff Bill Brown

Staff Present:

Toby Ewing, Ph.D., Executive Director	Tom Orrock, Triage Manager
Norma Pate, Deputy Director, Program, Legislation, and Technology	Kristal Antonicelli, RFA Project Lead
Filomena Yeroshek, Chief Counsel	Angela Brand, AGPA
Fred Molitor, Ph.D., Director, Research and Evaluation	Andrej Delich, AGPA
	Matthew Lieberman
	Cody Scott, Staff Services Analyst

WELCOME AND INTRODUCTIONS

Executive Director Toby Ewing opened the workshop at 9:42 a.m. and welcomed everyone. He provided a brief overview of the background on triage, Senate Bill (SB) 82 triage grants, and goals of today's forum on triage.

Sheree Lowe, Vice President, California Hospital Association (CHA), asked the Regional Vice Presidents (RVPs) and other representatives of the Hospital Association of Southern California (HASC), the Hospital Council of Northern and Central California, and the Hospital Association of San Diego and Imperial County to introduce themselves. She provided a brief overview of the impact of SB 82 on hospitals, the Emergency Medical Treatment and Active Labor Act (EMTALA), and things about hospitals unknown to the lay individual. She stated hospital personnel use the term "triage" differently than the SB 82 language.

FORUM GOALS

Commissioner Lynne Ashbeck asked all attendees to introduce themselves. She stated the objectives for today are to learn collectively, think creatively about triage, and refine

the Commission's understanding of the triage process in preparation for the next round of funding.

A member of the public added the goals of learning how to strategize, problem solve, network, and bridge gaps.

A CASE FOR COLLABORATION

Facilitator: Commissioner Lynne Ashbeck

Panelists:

Linda Molina, Division Manager, Orange County Health Care Agency
Ana Reza, Vice President, Patient Access Services, Hospital Association of Southern California
Whitney Ayers, RVP, Hospital Association of Southern California
Julie Hale, San Bernardino Department of Behavioral Health
Mindy Edwards, Program Director, Triage Navigator Program

Commissioner Ashbeck stated the need to learn strategies to improve collaboration. She asked today's panelists to discuss what worked, barriers to success, and what to do differently.

1. Orange County Presentation on County Triage and Working with Hospitals

- Securing a Service Agreement with the Hospital

Linda Molina, Division Manager, Orange County Health Care Agency, summarized the initial barriers, strategies to overcome, development and implementation, and lessons learned of the Orange County triage project.

Barriers and Challenges:

- Misperceptions and mistrust between counties and hospitals
- Lengthy contracting process
- Billing for services
- Data collection and sharing
- Staff experience and knowledge

Solutions, Strategies, and Successes:

- The triage grant was the resource required to bring the county and hospitals together to address the need.
- There was a mutual desire to meet the needs of clients.
- The narrow grant timeline helps counties and hospitals collaborate, focus on shared goals, and work through misconceptions.
- Integrated Record Information Systems (IRIS) and Powerform works well for data collection and sharing.

- Four-day county and hospital staff training involving over 30 representatives of county programs.
- Created an unprecedented way of assigning undesignated staff to shadow the mobile psychiatric evaluation team (PET) into the field to ensure that LTS have an understanding of what a risk assessment and 5150 determination involves.

Recommendations and Lessons Learned:

- Build and maintain trust between agencies
- Focus on solutions
- Follow through
- Understand the limitations and requirements of both sides
- Seek ways to partner with others to maximize efficiencies
- Establish mutual goals
- Focus on the client
- Understand that the triage grant process is time intensive and is a labor of love
- Include the Hospital Association in the triage grant application process
- Solution-focused, devoted leadership is critical
- Devote time to monitor the grant budgeting process
- Develop a data collection process
- Develop creative workflows for time efficiency and streamlining
- Create a training manual listing triage staff, target populations, PowerPoint presentations, hours of service, etc.
- Build trust by better understanding the other person's world
 - Help emergency department (ED) staff learn more about what it is to be a behavioral health provider out in the field doing behavioral health assessments and county documentation requirements
 - Help county staff to better understand the rapid needs, lack of space, and pressures of the ED

2. Hospital Procedures: Essential Components

- Staff Training
- Data Collection
- Creating Trust

Ana Reza, Vice President, Patient Access Services, HASC, summarized staff training, data collection, and creating trust in the Orange County triage project.

Barriers and Challenges:

- Internal culture, environmental, high volume, fast-paced, unpredictability of the ED
- Moving from a medical model to a recovery model
- Licensed triage staff (LTS) shift roles from treating to assessing, referring, and case managing
- IRIS data collection system is a county database and has limitations - it is not an EHR, there are delays in technical assistance, and the reports are raw data and time-consuming to evaluate
- Commitment from management staff that are stretched too thin
- Staffing and bringing in skilled behavioral health professionals into the ED setting
- Lack of financial and outpatient access service resources

Solutions, Strategies, and Successes:

- LTS training helps staff to understand the mission, vision, and model of the triage project and creates opportunities for transformation to be stewards of change in the ED.
- Training requires orientation, ongoing mentoring, and professional development.
- 38 training hours included the shift from a medical to recovery model, new interventions to assist the whole person health care, stigma and discrimination, multidisciplinary approaches, greater flexibility, program, orientation, contractual compliance and scope of work, county services training, IRIS training, and connecting to outpatient clinics with the crisis residential programs that they will be referring to.
- Training curriculum emphasized the recovery model, which is the catalyst of the recovery process and included guidelines, documentation gathering, effective communication, community resources, and self-care.
- Training is ongoing and consistent. HASC conducts additional trainings, meetings, and hospital site visits to identify areas of improvement.
- IRIS collects demographic information; employment, referral, and medical history information; connection to health care agency provider and county programs; and discharge summary identifying services and treatment, client response, and aftercare recommendations.
- IRIS feeds the collected fields into outcomes measures, such as wait times, crisis interventions and referrals, and linkages.
- Macros are being built into the raw-data IRIS reports for easier evaluation.
- The advantage of using IRIS is the ability to obtain client histories to identify previous linkages, such as other triage hospitals patients have gone to.

Recommendations and Lessons Learned:

- Tablets to replace hand-written notes at the bedside
- Consistency demonstrates reliability, which creates and maintains trust
- Cooperation in finding the middle ground
- Commit to the success of the triage project
- Transparency and honoring promises is important
- Responsiveness - be quick, timely, and professional in working with hospital staff
- Patience and persistence - collaborations take time
- Manage expectations
- Identify a trusted organization that knows hospitals

3. Hospital Administration: Getting Triage in the Hospitals

- Best Practices
- Barriers to Collaboration

Whitney Ayers, RVP, Hospital Association of Southern California, discussed helping counties and hospitals work together, streamlining the process, and administrative barriers that might prohibit a timely deployment of services. She stated the role of a RVP is policy, politics, and people. She discussed administrative things to think about to ensure a timely and efficient triage grant.

Staffing:

- Have firm deadlines in place for participation
- Identify clinical and administrative staff
 - Identify two leads per hospital that will participate
- Determine what the expectation is at each hospital
- County triage personnel or county contracted personnel working in the hospitals versus hospitals employing the triage staff

Billing:

- County contract with an LPS-designated hospital that the other hospitals respect and rely upon to deploy clinicians. This allows billing for crisis intervention.

Procurement:

- Counties are creative in how they structure agreements. Hospitals rely on counties to be creative and give them ideas.
- Most hospitals do not have the administrative support to respond to an RFP or an additional staff member to participate.

- The RVP is the primary contact when structuring agreements. Their role is to negotiate and boiler-plate agreements.
- An issue with counties in general is liability insurance limits.
- Talk to the county council up front when doing sole-source agreements.
- Counties use master agreements to bundle hospital agreements under one contract where the terms are all the same and make individually-signed agreement unnecessary.
- Talk about shared-service agreements with the hospitals. LTS hospitals may not require triage staff because they are already staffed, but non-LTS hospitals may require triage staff. One agreement per system is efficient.
- Talk about staffing requirements and sustainability.
- Get to know the local RVP.

Commissioner Ashbeck asked the panel members to speak about the law enforcement in triage projects.

Ms. Molina stated the Orange County Health Care Agency chose to partner with hospitals with their triage grant, but there is a direct benefit from partnering with law enforcement. Orange County already supports an approximately 40-staff 24-hour mobile PET team that rides along with the law enforcement officer for certain cities.

4. San Bernardino County: Presentation on County Triage and Working with Law Enforcement and Benefitting Hospitals

- Triage Engagement and Support Team (TEST)

Julie Hale, San Bernardino Department of Behavioral Health (DBH), summarized the initial barriers, strategies to overcome, development and implementation, and lessons learned of the San Bernardino triage project, TEST. The triage team works out in the field with law enforcement.

San Bernardino has had a mobile crisis team, the Community Crisis Response Team (CCRT), for the past ten years, but their call volume exceeds their capacity. The benefit of the triage program is that the response time of the mobile crisis team is often too great to be of benefit to law enforcement. San Bernardino County partners with the sheriff's department in providing crisis intervention training (CIT).

Many 5150 holds being written are avoidable - individuals who are not getting the care they need by sitting in hospital EDs. Getting in front of those holds impacts the whole system of care.

The distinction between the CCRT and TEST teams is that CCRT is 24/7, does crisis intervention, and refers to their TEST-embedded staff to do the ongoing case management. The rest of the TEST staff who are co-located at other sites do both the crisis intervention and the ongoing case management.

Barriers and Challenges:

- The first year is a lot of meetings, figuring out where to go, how to interpret the grant, and determining what the county wants to do with it
- Hospitals were not welcoming in the beginning
- Program confusion between CIT, CCRT, and TEST
- DBH and law enforcement looks at the results of background checks differently and can delay the hiring process
- The Memorandums of Understanding (MOUs) process is slow
- Sharing data
- Not enough triage staff to meet the need

Solutions, Strategies, and Successes:

- Create relationships with hospitals and law enforcement by going to many briefings talking about the program and learning about the gaps and what would be of use to them
- Triage staff do ride-alongs with new deputies to develop a relationship, to learn who they are, what is important to them, and what the triage team can offer them, and to educate the deputy about the role of the triage team
- Educate hospitals and law enforcement about the value of the triage program and how it can save them hours of time
- Have teams co-located at specific points of crisis access in the community to increase access to crisis services
- Help patients set up their ID, register for Medi-Cal, set up appointments, get to appointments, and wait with them in the waiting room to decrease barriers and ensure follow-through
- Collect data such as sit time in hospitals by law enforcement, transportation time that triage staff can do for law enforcement, and number of 5150 holds that are being written on a month-to-month basis to demonstrate the value of the triage team
- Ongoing communication - give out business cards with cell phone and land line numbers to support law enforcement and triage staff as they work together
- Survey law enforcement deputies and leadership about their experience with the triage program and how it can be improved

Recommendations and Lessons Learned:

- Understand that the MOU process will take time and cannot be sped up
- Build trust by using the more stringent law enforcement background check criteria for triage staff

5. Peer Navigators: Working in the Hospital Environment

- How Peers Benefit Law Enforcement and Hospitals
- Electronic Health Record Exchange

Mindy Edwards, Program Director, Triage Navigator Program at TLCS, summarized the initial barriers, strategies to overcome, development and implementation, and lessons learned of the Sacramento County triage project. She stated eight triage and eight peer navigators are at six private hospital EDs, Sacramento's main jail, and Loaves and Fishes.

Barriers and Challenges:

- Partners were reluctant to have paraprofessional staff in EDs
- Partners did not understand the value of peer navigators
- Hospitals were uncomfortable with having someone else's personnel in their EDs and were not used to private contractors
- Support for peer navigators is key
- Data collection and outcomes
- TLCS has an agreement with each hospital, but hospitals do not have agreements with other hospitals so no information can be shared between them
- TLCS is asking hospitals and jails to do high-level systems change, which is difficult - navigators have a hard job
- Confusion about the navigator role and that navigators do not necessarily reduce an individual's ED stay that day, but the follow-up over the next 60 days is what will help the individual not to return to that ED
- Confusion about the navigator role and that navigators do not stop arrests, but that they engage inmates who are there on short stays and give them an opportunity to connect to services

Solutions, Strategies, and Successes:

- TLCS partnered with the county and it took a lot of work and time to get into all the locations
- Critical to build trust and relationships with each partner
- Train triage staff in evidence-based practices
- Overcome the misconception that navigators will be extra work for hospitals; instead they will be a benefit to them, will save them time, and will be helpful
- It takes many meetings and a lot of communication with administration and clinical staff to create trust and show the value of including navigators in EDs and jails

- Navigators have access to the Sacramento County EHR to see if individuals are connected to any other services, which is something partners have not been able to do in the past - having a person there and then following up with that connection is helpful

Recommendations and Lessons Learned:

- Be flexible and creative
- Employ individuals with lived experience - they bring something to the table that is different from a licensed professional without lived experience doing an assessment or an engagement with an individual in the ED or jail
- Being available to partners is critical
- A team of triage and peer navigators in hospitals and jails is crucial to work on the back end to do the 60-day follow up, make appointments, transport, and employ the “whatever it takes” model to get people where they need to go
- Help triage staff feel supported in their challenging work environments - sometimes EDs and jails are traumatizing
- Employ individuals who are friendly and proactive - good at building connections and networking and letting people know who they are
- The triage grant process is not easy - there is reluctance and there is learning - but is worth it. It takes time and commitment
- High-level systems change is difficult and requires persistence to put the recovery model in areas where it has not been before

OPEN DISCUSSION ON COLLABORATION WITH HOSPITALS AND LAW ENFORCEMENT

Facilitator: Commissioner Lynne Ashbeck

Commissioner Ashbeck asked for questions on the hospital-centered model, the law enforcement-centered model with the hospital on the other end, and the peer navigator model.

How did San Bernardino County figure out how to share data with the sheriff's department?

Ms. Hale stated it is in the MOU. The triage staff enters the name and date of birth into the Data Collection Sheet and the hospital or jail gives them first encounter information, incarcerations, and recidivism. Also, the county can run the names through their system to determine if the patient has been linked to an outpatient clinic and number of times hospitalized. A challenge is that hospitalization in one of the contracted LTS-designated hospitals cannot be verified because that information cannot be shared. Data is also gathered from the CIT that law enforcement fills out for each person with mental health issues they have interaction with, which leads to a hold. There is not one way to collect.

What are you doing different or special for homeless individuals?

Ms. Edwards stated the majority of individuals served are homeless due to the housing crisis in Sacramento County. Those are the individuals who fall through the cracks in the mental health system. Their need for housing is the only difference, so TLCS takes them to get TB tests and IDs so they can get into shelters and puts them on housing waiting lists.

Ms. Ayers stated a best practice in L.A. and Orange Counties is the shelter-based Recuperative Care Program. CalOptima is the managed care plan, which pays 75 percent of the costs (\$150/day) for 15 days for homeless individuals who need aftercare or 90 days as part of the Whole Person Care pilot program at no cost to the hospital. Licensed clinical staff will soon be added for these patients.

Ms. Reza stated the triage staff coordinates and collaborates with the internal social work department because that is typically where the recuperative care piece falls into place.

Ms. Hale stated the DBH outreach program, which has access to some of the housing options, is on-call to do assessments in the field. The DBH has a temporary shelter, the clinics have options for housing, and law enforcement has the HOPE program and TEST partners with them.

Where does the information go that the EDs input into the IRIS but cannot retrieve personal information because of HIPAA laws? Who gets that information and is it tracked across county lines?

Ms. Molina stated the county, its contractors, and the hospitals input demographic data for clients into IRIS, which serves as an EHR for the county. The hospitals input two levels of recording and have access to the information of the clients they are serving. The contractors and other counties do not have access to the information in the IRIS system.

How are resources found for patients? Is there an electronic database that patient navigators use for resources in the EDs and co-locations or do they use placement agencies for board and cares?

Ms. Reza stated the three key resource guides are a resource directory that was created during the robust HASC training program, the 2-1-1 Orange County: Connect, Collaborate, Inform online resource database, and OC Links for county behavioral health programs.

Commissioner Ashbeck stated San Diego is an example of how 2-1-1 should work, but it is not that way across the state. There is an opportunity as a collaboration of hospitals, law enforcement, and peers to help increase the utilization of 2-1-1 programs statewide.

How are resources given to patients? Are they referred to a website or handed something tangible with an appointment for the next step?

Ms. Hale stated, if patients are interested in ongoing involvement, the DBH will do all of that with them. If they are not, there is a variety of options given to them. The DBH also does not take no for an answer but does multiple follow-ups.

Is there a decreased length of stay for ED boarding and, if so, how much?

While Shasta County has co-located mental health workers, not that much of a decrease in boarding times has been documented. In fact, individuals have boarded in the ER for 40 days.

Boarding times are defined as the length of time individuals stay in the ER beyond 72 hours.

Ms. Molina stated that is a critical area that Orange County will be looking at. That data has just begun coming out of the IRIS system. She stated she does not expect a decrease - demand has increased while inpatient bed space has not.

Commissioner Ashbeck asked participants for one thing they would like to see driving the next round of triage grants that would make a difference for counties, communities, and the individuals who are getting lost between the counties, hospitals, and law enforcement.

- Help counties collaborate together to develop inpatient beds and additional resources to get patients to the right care at the right time and in the right place
- Take patients that are 5150 out of a non-LTS hospital ED to something like a crisis stabilization unit (CSU) but with an expanded scope
- Allow successful triage grant projects an extension so they can gather more data because three years is too short a time to gather significant amounts of data
- Improve information sharing from a provider standpoint so that everyone is on the same page to provide the best care and best service for patients
- Streamline the process for modification of the program foundation and from what was in the original grant
- Easy access programs for patients with dual diagnosis of substance use and mental health problems - detox centers would be helpful, similar to San Antonio's one-stop shop
- More coordinated care management for frequent users who are high risk
- Start at the state level to begin to cobble together programs instead of isolating them in silos
- Continue to ensure better funding through Medi-Cal
- Help on cross-county collaborations and services
- Expand successful models

- Support CSU staff
- Workforce development
- Add funding to improve data sharing capability
- Include technology in problem solving for rural counties
- Clarity between the DHCS and CMS about the use of CSUs
- Include H&I Dual Recovery Anonymous (DRA) 12-step programs to help clients in the recovery process
- Flex dollars to link patients to services such as FSPs and WRAP

TRIAGE IN COUNTIES, HOSPITALS, AND LAW ENFORCEMENT: THE SYMBIOTIC RELATIONSHIPS TRIAGE CAN CREATE IN SMALL, RURAL, OR GEOGRAPHICALLY CHALLENGING COUNTIES

Facilitator: Commissioner Bill Brown

Panelists:

Brenda Hanley, Sheriff Liaison, Calaveras County Health and Human Services Agency

Noel J. O'Neill, LMFT, Director, Trinity County Behavioral Health

Commissioner Bill Brown provided an overview of the collaborative triage model in San Antonio, Texas, that brought law enforcement, mental health, hospitals, businesses, non-government organizations, and faith-based communities together to effect systems change by establishing two co-located one-stop shops to connect patients to the right resources - the Restoration Center and the Haven for Hope. He stated one of the reasons for their success is that they adapt the program to the need.

1. Calaveras County: Mitigating Recidivism

- The Importance of Triage Personnel Placement
- 5150 Authorization

Brenda Hanley, Sheriff Liaison, Calaveras County Health and Human Services Agency, stated she is the one triage staff member in her county and she employs the “whatever it takes” philosophy in the implementation of the Calaveras County triage project.

Recommendations and Lessons Learned:

- Build close relationships with law enforcement, EDs, and school counselors
- Work nontraditional hours to be available to support law enforcement on weekends and evenings
- Do home visits
- Help inmates obtain a Medi-Cal card and make them an appointment for intake before they are released from prison - an intake appointment during the first week after release increases the chance of continued engagement

Advantages of Triage Personnel in Writing 5150s:

- Save time for law officers by writing up 5150s or transporting clients
- Build trust with law enforcement
- Understand law enforcement and jail culture

2. Trinity County: Integrating Crisis Services

- Memorandum of Understanding
- California Health Facilities Financing Authority (CHFFA) Funding

Noel J. O'Neill, LMFT, Director, Trinity County Behavioral Health, provided an overview, accompanied by a slide presentation, of the interventions, fiscal considerations, data and outcomes, problems and solutions, and crisis services transformed by the Trinity County triage project.

3. Nevada County: Diverting Crises from Hospitals

This item was not discussed.

Questions for Panel 2

How do you change the perspective of the law enforcement who come in contact with individuals experiencing mental illness and how effective is law enforcement?

Ms. Hanley stated officers come to her with questions from what they have observed out in the field and she has helped them understand.

Mr. O'Neill stated everyone in Trinity County is progressive and cares about the residents of their county as human beings. He stated the county government is supportive of the contracts and initiatives he has brought before them.

What percentage of the individuals cared for are Medi-Cal beneficiaries?

Ms. Hanley stated the vast majority of the individuals she comes in contact with are Medi-Cal or Medi-Cal eligible.

Mr. O'Neill stated 24 percent is Medi-Cal, 6 percent is part of the Projects for Assistance in Transition from Homelessness (PATH) grant, 3 percent is IGT funds, 47 percent is SB 82, and 20 percent is MHSA outreach and engagement. The biggest issue with Medi-Cal is many of the triage workers are not licensed clinicians, so the county must be careful about the scope of practice.

Do you see opportunities for regional partnerships across counties?

Ms. Hanley stated a tri-county partnership would be helpful in her area.

Mr. O'Neill stated the marijuana industry attracts tourists to Trinity County from the East Coast who often end up in the EDs. The goal is to get them back to where they came from. Inpatient hospitalization has been discussed in Trinity County and regional partnerships would be welcome, although the county would prefer that most mental health activities remain local due to the vast distances. Eight counties in the Superior

Region are working with the Partnership Health Managed Care on the drug Medi-Cal side and will submit a regional plan to the DHCS soon.

The Wellness Center in Stockton has a person-first approach. What is successful for other wellness centers? What do they have to offer?

Mr. O'Neill stated all the staff are peer specialists who have full benefits as employees of the county. Peer Mentor Coordinators help organize the system within the wellness center.

OPEN DISCUSSION: KEY TAKEAWAYS FROM TODAY'S DISCUSSION

Facilitator: Commission Vice Chair John Boyd, Psy.D.

Vice Chair Boyd stated the goals of this agenda item are to ensure everyone has been heard, to ensure that the themes have been captured, and to proactively cover what has been heard in other forums that was not heard so much here. He summarized the themes brought out today and asked for input:

1. Find your champion for a successful launch and timely approval and execution

Find champions at both the administrative and operational levels

2. Challenge: Length of time required for agreements and MOUs

Plan for the amount of time it will take to do the work and be patient

Incentivize agreements such as a letter of intent early in the application process to help push people to the table faster

Include in the RFP that an MOU must be in place, or evidence that the county is working towards it and is close, by the end of year one

Convene quarterly meetings that document how entities are working together toward an agreement and track that collaboration is happening

3. Collaboration

There is a need for a resource of county solutions to common issues for other counties to learn from and use as models and best practices

County progress and evaluation reports should be posted on the MHSOAC website to give counties, hospitals, and community members ideas of what other counties are doing and how it is working, which is a way for counties to connect and reach out to one another

The CHA has a map that describes the level of CSUs and other resources available throughout California

4. Understanding culture

Include LGBTQ, immigrant, and older adult populations in the scenario for not receiving treatment, falling through the cracks, and addressing linguistic differences

5. Leveraging CHFFA

Gather ideas from counties that are thinking of how to help support the crisis continuum that was created in the first round of triage grants and continue to support the infrastructure that was built using the CHFFA funds

Schools are a logical potential partner for the next round of CHFFA grants that focuses on children and youth

Collaboration and connection with law enforcement is vital to hospitals, schools, and the community

6. Data collection challenges

Measure the reduced hours that individuals stay in EDs, not just the reduced number of individuals who go to inpatient care

7. Will the MHSOAC entertain ongoing support for existing projects?

Base ongoing support on evidence of successful outcomes, especially for small counties where reapplying for round two would be cost-prohibitive

All counties have resource challenges - base ongoing support on evidence of successful outcomes regardless of county size

It was difficult, challenging, time-consuming, and took resources to get the first-round projects going, and they are now to the point where good data collection is happening

Counties need to factor in cost-savings on the back end - as counties spent funding on the front end to solve the problem, most of the data shows a reduction in the volume and the number of days patients stay in inpatient hospital beds, which is a cost-savings to counties

Look at Medi-Cal rules and regulations and how they can stifle the flexibility that makes these programs work

8. Should the MHSOAC bring evaluation in-house?

Ask law enforcement, hospitals, and schools what they can contribute to valuable programs for sustainability

Counties will continue to be under pressure about what their programs contribute to the community, even if the evaluation component is given to the MHSOAC or a third party

Unsure if an external evaluator can uniformly measure and evaluate the metrics collected on the entire program due to the diversity of the programs and counties

Post the required set of metrics that counties must collect prior to the application process so counties understand what needs to be measured before they apply

9. RFP Structure

The RFP structure should be in two parts: new applicants and existing applicants

More clarity on whether the SB 82 grants will be ongoing

More clarity on flex funds for intangibles that are necessary for counties to be successful, such as transportation and cultural training, since the first round was restrictive - there should be a line item that allows for training, travel, and whatever it takes

CLOSING REMARKS AND NEXT STEPS

Tom Orrock, Manager, Triage Grants, stated the MHSOAC will continue to listen to stakeholders, meet with county coordinators, and work on the second round of the SB 82 triage grants. He encouraged everyone to continue to provide input throughout the process.

Kristal Antonicelli, Lead Triage Staff, summarized the next steps of the second-round Request for Application.

ADJOURN

There being no further business, the meeting was adjourned at 3:45 p.m.